



Los Angeles County Commission for Women (LACCW)  
EVENT FUNDING REQUEST FORM

*All requests for funds should allow LACCW 30 days to make a determination. The requesting Commissioner must provide the following information before consideration of a request*

Name of Commissioner(s)

Los Angeles County District

Yolanda Becerra-Jones

- Presidents Fund

2nd

Amount Requesting: \$500

Purpose of Usage: ☐ Ticket(s)

☐ Donation

☒ Other (specify)

Cover luncheon

Organization's Name: Los Angeles County Perinatal Mental Health Task Force

Address: c/o Community Partners, 1000 S. Alameda Street, Suite 240, LA 90023

Street

City

Zip

Telephone Number: 213-346-3200

FAX Number:

Website Address: [www.laperinatalmentalhealth.com](http://www.laperinatalmentalhealth.com)

E-mail: [kwong@pubdef.lacounty.gov](mailto:kwong@pubdef.lacounty.gov)

Contact Person (Name and Position): Kimberly Wong

Event Information – Name, Time and Location:

Community Awareness Forum on Perinatal Depression at Harbor UCLA Hospital  
Wednesday, April 20th from 12-1:30 pm

Event Information – Purpose and Goals: (Event publicity materials may be included (optional))

Community Awareness Forum hosted by Harbor UCLA in conjunction with the LA Perinatal Mental Health Task Force to bring awareness to perinatal depression among health care providers and the community. Supervisor Ridley-Thomas' office prepared a proclamation for the event and will be sending a representative.

Constituency served within Los Angeles County (age, gender, ethnicity, income level, geographical region, etc.):

Health care providers of all backgrounds working at Harbor UCLA and serving 2nd district constituents. Constituents include women of child bearing age and their families who are uninsured or underinsured with emphasis on Latino and African Americans.

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How will your attendance or donation to this event benefit the LACCW?

The CW will help to promote an event that will encourage awareness about perinatal depression and highlight the leadership of the 2nd district in prioritizing maternal mental health and reducing stigma

Have you participated in this event before representing the LACCW?

No ( ☒ ), this is the first time.

Yes ( ☐ ), I have attended prior to this one. Year(s): \_\_\_\_\_

Have this organization received donation fund from LACCW before? If yes, please specify the event, time, and amount of donation. If more than once, please specify the two most recent occasions.

First Occasion: \_\_\_\_\_

Second Occasion: \_\_\_\_\_

*Please send this form to:*

**Los Angeles County Commission for Women**  
**500 W. Temple Street, Rm. B-50, Los Angeles, CA 90012**

**PH: 213-974-1455**

**FAX: 213-633-5102**

**E-mail: rrangel@bos.lacounty.gov**

***For CW Office Only:***

(Yes ☐ ) (No ☐ )

Place on Agenda

\_\_\_\_\_  
Date Received

\_\_\_\_\_  
Received By

\_\_\_\_\_  
Date of Review

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Reason for not placing on agenda

\_\_\_\_\_  
Date of CW Board Meeting

(Yes ☐ ) (No ☐ )  
\_\_\_\_\_  
Action Taken

(Yes ☐ ) (No ☐ )  
\_\_\_\_\_  
Notification Sent

\_\_\_\_\_  
Amount Approved

\_\_\_\_\_  
Reason for Rejection

Approved 9/13/10